MONTANA CHEMICAL DEPENDENCY CENTER POLICY AND PROCEDURE MANUAL

Policy Subject: Health Information Compliance	
Policy Number: MRP 01	Standards/Statutes: ARM 37.27.120 MOM Section 1-0870.00
Effective Date: 01/01/02	Page 1 of 7

PURPOSE:
To provide guidelines for Health Information/Medical Record compliance.

POLICY:
A written medical record shall be maintained on each patient formally admitted to this facility. Medical/Clinical records will comply with all federal, state laws and regulations.

PROCEDURE:

I. The patient record is designed to substantiate that the clinical and medical services provided are necessary, relevant and beneficial. The patient record documents clinical and medical data, assessments, and treatment is designed to address the problems identified through the assessment process.

II. The Medical Record system utilized is the problem oriented health record.

III. Upon admission or when medical issues arise the patient is assessed by a member of the Medical Staff, which includes the Medical Administrator (physician), Registered Nurses, Licensed Practical Nurses and Treatment Specialists. The Medical Staff is responsible to document in the record and to assure all issues are in chronological order and to be legible.

A. Only approved abbreviations and symbols for use in documenting in patient records and in interpreting orders will be used by MCDC staff.

IV. Chemical Dependency Counselors, Mental Health Professionals and others working with a patient are responsible to keep the patient's record current, in proper order and legible.

V. The confidentiality of patient records will be maintained in accordance with Federal Register, Volume 40, NO. 127, Part IV at all times. Information contained in the Medical record

is confidential and shall be protected from perusal by unauthorized persons. The original record is the property of the facility and is not to be removed from the facility except under court order. Copies of the record may be released with a proper-signed release of confidential information form or by a court order.

A. A state, district, or federal court may issue an order to authorize a program to make a disclosure of patient-identifying information. A proper court order will usually state specifically that it is being issued pursuant to the federal confidentiality law and regulations (42 U.S.C. {{209dd-2, 42 C.R.F. Part 2).

B. A subpoena, search warrant or arrest order is NOT sufficient to require or even permit a program to make a disclosure even when signed by a judge.

1. Information may be released at the discretion of the patient about whom the information is being sought if he/she signs a proper consent form authorizing the program to release the requested information. This occasionally happens while a patient is still in treatment and officers have papers to serve.

a) If a police officer, process service or other professional identified server arrives to serve legal documents on a patient, ask the officer to have a seat for a few minutes not giving any indication that the person is here. Contact the counselor if available, if not another staff member from another office away from the officer's hearing. Inform counselor, supervisor, or charge nurse that legal documents are to be served on the patient and have the counselor ask the patient if he/she is willing to sign a release form and accept the court papers. If the patient signs the release form, the patient will be brought to the first floor to be served. The release form is to be retained in the medical record.

b) If the patient declines to sign a release form, indicate to the person presenting the documents, not giving any indication if the person they are looking for is here or not. The statement to use is: Federal regulations prohibit me from telling you if the person you are requesting is here or not.

c) If the server does not accept that answer, or becomes argumentative, contact a supervisor or the Administrator to speak to the officer.

VI. Confidential information will not be released without a written release of information form completely filled out and signed by the patient or his/her authorized representative. (Except as explained above regarding a proper court order.)

A. The written consent must meet the following criteria.

1. The name of the patient

2. Specific information to be released

3. Name of the person, agency or organization to which the information is to be disclosed

4. The purpose of the disclosure

5. Date the consent was signed, signature of the patient, signature of witness to the consent

6. Revocation statement is stating the specific duration for which the consent is valid. The patient may revoke the release at any time, except to the extent that action has been taken in reliance thereon by notifying the Medical Record Department.

B. If a release is revoked notify Medical Record personnel who will retrieve the record and mark across the consent form REVOKED and date and initial the form.

VII. Policy and procedures, along with state and federal requirements will be followed in order to release information in an appropriate manner from a patient's medical record by correspondence.

A. All correspondence is logged in the correspondence logbook, which is kept with Medical Record support staff. The patient's ID number, name, brief statement of type of correspondence, where sent, and date sent is logged.

1. Verify ID number by checking Master Patient Index (Master Patient Index is a database of all persons admitted to MCDC. Information recorded in the index is used to provide information and as a reference tool for various authorized treatment center staff and other agencies with a proper release of information. The permanent index database is used in the collection of statistics; as a permanent record of persons treated at MCDC; record retrieval, etc.) and retrieve medical record prior to answering any type of correspondence.

2. Assure that the authorization for release of information, which accompanies is a proper release and meets all necessary criteria. If not, send form letter and proper release to the requesting party to be signed and sent/faxed back.

3. File release form in the medical record when the information is sent. On the release state exactly what information was sent, date and initial the entry.

4. Answer all correspondence efficiently, courteously and as quickly as possible.

VIII. Staff members and other persons having access to patient records shall be required to

abide by Federal and State laws and regulations and MCDC policy and procedures. Any employee violating these regulations and policy and procedures may be subject to disciplinary action and/or termination at the discretion of the Program Administrator.

A. Medical records may be made available for in house use by professional staff for data gathering and audit purposes while maintaining individual confidentiality status without authorization from the patient.

B. Professional staff has access to files to accomplish their work assignments upon request. In rare instances when the record must be removed from the medical record area it is required that the staff member sign it out. Records are to be returned to the department by the end of the workday.

1. Employees, other than professional staff, must have written authorization from their supervisor.

C. Any patient currently in treatment may be allowed the opportunity to review his/her medical record, however do not allow the patient to read the record. It is generally not beneficial to the patient to read information, which may not be understood; therefore arrangements must be made with the Chemical Dependency Supervisor, attending physician or primary counselor to review the record with the patient.

D. Only authorized people are allowed the Medical Record Department after working hours; physician, Administrator, Chemical Dependency Supervisor, Administrator of nurses and medical record administrator. Housekeeping staff has access to the department, but at no time are they to have contact with patient records.

E. When in doubt about releasing information, consult the Medical Record Administrator. Final authority for decisions regarding release of information from the medical record rests with the Center Administrator.

F. All press inquires are to be referred to the Center Administrator.

IX. Every staff member and every site visitor is required to sign a statement regarding confidentiality, which insures awareness of the guidelines and an agreement to maintain a confidential posture toward all clinical information in accordance with federal regulations.

A. As part of orientation new employees is trained in Patient Confidentiality, they are also given a copy of the federal confidentiality law and regulations and required to sign an employee confidentiality form.

B. When visitors (family, friends, salespersons, vendors, repairperson, etc.) arrive at the facility they are required to sign in the log with name, date, and reason for visit. All

persons must sign a visitor's form. For regular visitors such as vendors only one form per year need be signed and kept on file, but the log must be filled in on each visit. A visitors ID badge will be given to each person entering the facility and collected from them as they the logbook, forms and ID badges will be at the front desk. It is the responsibility of the front office personnel to assure that the above is completed during regular daytime working hours (8:00a.m. - 4:00p.m. M-F) and either treatment specialists or medical staff on weekends and after hours.

X. In a life-threatening situation, MCDC may release pertinent medical information to the medical personnel responsible for the patient's care without the patient's consent and without the authorization of the Administrator or a designee, if obtaining such authorization would cause an excessive delay in delivering treatment to the patient. When information has been released under emergency conditions, the staff member responsible for the release of information shall enter all pertinent details of the transaction the patient's record, including at least the following items:

A. Date the information was released

B. The person to whom the information was released

C. The reason the information was released

D. The reason the consent could not be obtained

E. The specific information released

XI. The patient shall be informed that the information was released as soon as possible after the release of information was furnished for emergency conditions. Notification may be in writing or verbal. A copy of the letter informing the patient of the release should be kept in the medical record. If verbal notification is given that information needs to be documented in the record giving date of notification, time, telephone number called and any other specific information detailing the conversation.

XII. The medical record shall contain specific forms, reports, graphics, flow sheets, medication administration record sheets (MARS), signed releases, progress notes (to be complete and updated as events occur or as seen by either medical or treatment staff), treatment forms, etc. for both the medical and treatment aspects of the program and be filled in the record in precise order following criteria contained on the file management form. The file management form is located on the left front cover of the medical record.

XIII. Diagnosis appearing on the physical exam form will be coded using ICD-9 criteria on the physician service slip for each new admission physical and each subsequent physician visit. This is a reimbursement requirement to ensure proper reimbursement from Medicare, Medicaid, Insurance companies and patients. Coded physician service slips will be sent to the DPHHS

reimbursement office in Helena on a weekly basis.

A. The physician is responsible to supply correct and current diagnosis on the physical exam and physician service slips.

B. Using knowledge of ICD-9 coding procedures, medical diagnosis, medical terminology and physician's desk reference manual determine the proper category of patient diagnosis by referring to ICD-9 coding manual book one and cross referencing diagnosis in ICD-9 coding manual book two. Code physician service forms and laboratory forms. Assure that correct date, time physician's license number and physician's initial has been obtained.

C. Electronically log, batch number and send to the Department Reimbursement Office in Helena, MT.

XIV. Closing/retiring of a patient medical record is completed after the patient has been discharged. The permanent medical record will be assembled in correct chart order. Chart analysis will be completed to assure that all necessary forms are present, completed and signed. After analysis is completed the record will be retired permanently, or until such a time the patient is readmitted.

A. It is required that the completed medical record be delivered to the Medical Record Department within 48 hours or two working days of the patient's discharge. This is to include a completed draft of the discharge summary; patient treatment record and medical segment of the record.

1. Medical Record staff will check the electronic discharge summary for correct form; punctuation; spelling; etc. Once the discharge summary checks have been performed, it will be printed and submitted for the treatment counselor's approval and signature. In counselor's absence submit to Chemical Dependency Supervisor.

2. After discharge summary has been signed copies will be sent either by mail or fax to the agencies listed on the discharge summary after checking to assure that proper release of information forms are in the record.

B. Each page of the chart will be checked for completeness and required signatures. File each page in appropriate order following the file management form. If forms are missing or a signature needed contact the responsible party for missing item or signature.

C. When above is complete each page in the medical record will be stamped with a MCDC CLOSED stamp after the last entry on the page.

D. The Master Patient Index card will be completed with the discharge date; number of

treatment days added and filed in alphabetical. Retired record is filed in numerical order in proper storage area.

XV. It is the State of Montana policy and of MCDC to follow retention schedules of the office of the Secretary of State to retain and maintain patient and employee medical records for at least ten years from the date they are officially closed or for ten years after the last face to face contact with the patient.

A. Prior to destroying any medical record it is necessary to submit a Records Disposal Request form to the state records committee. The following signatures must be secured form are Legislative Auditor, Attorney General, Administrator of the Historical Society, Administrator of the Dept. Of Administration and the Secretary of State.

B. Once permission is obtained from the Secretary of State the records will be destroyed, either by shredding or burning, under the direct observation of staff, in order to assure confidentiality of patient information.

C. No records shall be destroyed at any time an audit is in process or if there are any litigation's or claims against the records, which remain unresolved.

Revisions:

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